Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Charleston Hand Therapy Center's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I authorize the following uses or disclosures concerning the use of my personal medical information:

- ☐ Leave messages concerning my appointment time at home / work / cell
- ☐ Allow my appointment time to be scheduled, cancelled, or rescheduled by my spouse / other _____
- ☐ Accept payment or discuss payment arrangements on my account with my spouse / other _____
- ☐ Leave messages concerning payment at home / work / cell
- ☐ Other _____
  _____

I request the following restrictions concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ **Witnessed by:** _____

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title):_____